

NORTH STONINGTON RECREATION COMMISSION

ADULT MEDICAL INFORMATION

PLEASE PRINT:

NAME \_\_\_\_\_ HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

EMERGENCY CONTACT	ADDRESS	TELEPHONE
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EMERGENCY CONTACT	ADDRESS	TELEPHONE
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LOCAL PHYSICIAN'S NAME \_\_\_\_\_

FULL ADDRESS \_\_\_\_\_

OFFICE PHONE \_\_\_\_\_

LIST All Allergies, Medical Restrictions or Other Existing Medical Conditions: \_\_\_\_\_

Additional Remarks or Instructions: \_\_\_\_\_

Please List Any and All Medications You Are Currently Taking: \_\_\_\_\_

STATEMENT OF HEALTH AND PERMISSION FOR MEDICAL CARE

I hereby certify that I am in excellent health, and I may participate in strenuous physical activities. I further certify that there are no limits to my participation except as stated in writing and included on this form. I understand that if I have an allergy that needs immediate medical attention, I must be responsible for my treatment.

In case of an accident or injury when I am not fully alert and in control of my senses, I hereby authorize the North Stonington Recreation Commission's (NSRC's) agent to call the above designated emergency contract persons. If the NSRC's agent is unable to reach either person, I hereby authorize the agent of the NSRC to call the physician indicated above, and to follow his/her instructions. If it is impossible to contact this physician, the NSRC's agent may make whatever arrangements seem necessary for my medical care.

I have read and I do understand what I am now about to sign.

NAME \_\_\_\_\_ DATE \_\_\_\_\_

PLEASE MAIL TO: NSRC, 40 Main Street, North Stonington, CT 06359

PROGRAM	DATES	TIME	FEE
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